	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	A. BUILDING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/03/2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE	1 00/00/2	· · ·
UNIVERS	SITY PARK HEALTH	I AND REHABILITATION CENTER		FORT \	WAYNE, IN46825		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
F0000	State Licensure Sincluded the Investigation Included Survey dates: February 2011 Facility number: Provider number	lue to a lack of evidence. bruary 28, March 1, 2, 000459 : 155567 100289700 , RN TC	F00	000	This Plan of Correction is the center's credible allegation of compliance. Preparation and/execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the factualleged or conclusions set for the statement of deficiencies. The plan of correction is prepared for executed solely because is required by the provisions of federal and state law.	e ts th in ared se it	
I A DOD ATTOR	V DIDECTORIC OR PROV	Thed/CIIDDI IED DEDDESENTATIVE'S SIGN			TITI E		(V6) DATE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 000459

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155567		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			survey eted 011	
	PROVIDER OR SUPPLIER	HAND REHABILITATION CENTER		STREET A	DDRESS, CITY, STATE, ZIP CODE EDICAL PARK DRIVE VAYNE, IN46825		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		es also reflect state dance with 410 IAC 16.2.					
	Quality review concepts Cathy Emswiller						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 155567 03/03/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1400 MEDICAL PARK DRIVE UNIVERSITY PARK HEALTH AND REHABILITATION CENTER FORT WAYNE, IN46825 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE It is the policy of this facility to F0272 Based on interview and record review, F0272 04/01/2011 conduct initially and periodically the facility failed to evaluate bowel SS=D a comprehensive, accurate, continence after a change in bowel standardized reproducible continence status for 1 of 3 residents assessment of each resident's reviewed for bowel continence in a total functional capacity. Resident #84 was transferred on 2/11/11. Due sample of 18. (Resident #84). to this, facility unable to perform corrective action with affected Findings include: resident. Clinical records were reviewed for Bowel and Bladder Assessments to determine if any Resident #84's record was reviewed other resident was affected. 3-2-11 at 10 a.m. Resident #84's None were found. Licensed diagnoses included, but were not limited nursing staff to be re-educated on to, diabetes, high blood pressure and proper documentation of Bowel and Bladder Assessments. stroke. Bowel and Bladder Template to be utilized in MAR with a 3 day Resident #84's Bowel and Bladder voiding pattern after admission or Assessment and Management form dated readmission. Upon the 4th day, bowel and bladder assessment 1-16-11 indicated Resident #84 was will be completed to ensure continent of bowel, needed assistance to accuracy. The DON or designee the bathroom, and had minor functional to monitor Bowel and Bladder impact on his bowel status from health Template in MAR daily. Upon completion of Bowel and Bladder conditions; and was a possible candidate Assessment, Unit Manager will for retraining. The back of the Bowel review Assessment and Template and Bladder Assessment and Management to ensure accuracy and form indicated under management completion. Addendum: The DON or designee to monitor Bowel and program, Resident #84 was not a Bladder Template in MAR daily on candidate for retraining as he was newly admitted or readmitted continent of bowel. residents.. Upon completion of Bowel and Bladder Assessment, Unit Manager will review A Physician's progress note dated 2-5-11 Assessment and Template to indicated Resident #84 had been recently ensure accuracy and completion. readmitted after hospitalization with a Quality Assurance to review stroke leaving his left side not moving. results monthly x6 months or until

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VH0H11

Facility ID:

000459 If continuation sheet

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/03/2011		
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	_		ADDRESS, CITY, STATE, ZIP CODE		
			n	1	EDICAL PARK DRIVE		
		H AND REHABILITATION CENTE	· · · · ·		VAYNE, IN46825		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	
TAG	Resident #84 wa facility on 2-4-20 Bladder Assessm form dated 2-4-1 was incontinent of assistance to the functional impact conditions; despite continence. The the back of the Electron Assessment and management professes was a candid. In an interview of the Regional Clift the facility should assessment and electron A current policy Maintenance Proprovided by the Assessment and electron assistance and functional status possible1. Upon continence status	s readmitted to the 011. His Bowel and nent and Management 1 indicated Resident #84 of Bowel, needed bathroom, and had minor at from his health ite his change in bowel are was no indication on Bowel and Bladder Management form under agram whether Resident date for retraining. on 3-3-2011 at 10 a.m., nical Director indicated do have completed the evaluation. titled Continence agram dated April 2011 Administrator on m. indicated "It is the to identify residents with sess contributing factors, maintain the highest of continence deemed on admission, evaluate the sand determine the lof assistance and needed to meet		TAG	pattern of consistent complian achieved with a subsequent pl developed and implemented a indicated.	an	DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155567			A. BUILDING		COMP	COMPLETED 03/03/2011	
	PROVIDER OR SUPPLIER		1400 M	ADDRESS, CITY, STATE, ZIP CODE EDICAL PARK DRIVE NAYNE, IN46825			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	3.1-31(c)(11)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPL	ETED
		155567	B. WING			03/03/2	011
			D. WII (ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				MEDICAL PARK DRIVE		
UNIVERS	SITY PARK HEALTH	HAND REHABILITATION CENTER			WAYNE, IN46825		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0281	Based on intervio	ew and record review,	F0281		It is the policy of the facility the		04/01/2011
SS=D	the facility failed	to ensure			services provided or arranged the facility must meet professi	- 1	
-	communication with other members of				stands of quality Resident #.		
	the nursing team	with regard to			physician orders reviewed by		
	_	nistration for 1 of 15			DON. Transcription Error repo	ort	
		ed for medication			written by LPN #1 and DON for		
		a total sample of 18.			Enablex error. LPN #1 noted		
		a total sample of 18.			Enablex into March MAR.		
	(Resident #24)				Attending physician and Resid	dent	
					#24 notified of error. DON or designee to perform facility wi	do	
Findings include:				review of all residents' MARs			
					ensure accuracy with physicia		
	Resident #24's re	ecord was reviewed			orders. Licensed nursing staff		
	2/28/11 at 1 p.m.	Resident #24's			re-educated on proper Medica	ation	
	diagnoses includ	ed, but were not limited			Administration and Monthly		
	to, depression, ar	nemia, and osteoporosis.			Re-write of MARs protocol. U	nit	
	, 1	, 1			Managers will review 50% of residents' MARS upon comple	tion	
	A physician's ord	ler dated 2/25/11			of monthly re-writes for 3 mon		
		Enablex 7.5 mg to be			Unit Managers to report findir		
		C			to DON. DON or designee to	Ŭ	
	given every day	for overactive bladder.			perform random reviews of		
					re-writes for 6 months of		
		lministration Record			residents' MARs. Quality		
	_	011 indicated Enablex			Assurance Committee to mon for 6 months. Addendum:Unit	ILOT	
	had been started	2/27. There was no			Managers to report findings to	,	
	signature indicat	ing the medication had			DON. DON or designee to		
	been given on 2/2	28.			perform random reviews of		
					re-writes monthly for 6 months	s of	
	The Medication	Administration Record			residents' MARs. Random		
		1 did not list Enablex as			reviews to be 10% of resident	S.	
		t was to be given.			Quality Assurance to review results monthly x6 months or		
	a modication tha	55 51 7011.			until pattern of consistent		
	A rayian aftha	nurrant physician's anders			compliance achieved with a		
		current physician's orders			subsequent plan developed a	nd	
		he medication Enablex			implemented as indicated.		
	had been discont	inued.			Re-write process is as inservio	ce	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/01/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	CONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/03/2011		
	PROVIDER OR SUPPLIER		B. WING 05/05/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DRIVE FORT WAYNE, IN46825				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE	
	LPN #1 indicated been given. Additional ordered the last with be noted on the random taking the order. In an interview of LPN #1 indicated without indication of administration Administration Factor of Acopy of the Ensupplied by the Insupplied by the Insupplied to the fact tablets had been an interview of LPN #1 indicated medications, upon usually given, with Medication Administration properties of the Medication Administration properties of the Medication Acommunicate with administration properties of the Medication properties of t	ablex medication card Director of Nursing on ed 16 tablets had been acility on 2/26/2011. 4 taken from the card. on 3/2/2011 at 2:05 p.m., d the nurse administering on finding a medication, as not listed on the inistration Record, fied the medication was wrote the medication on administration record to th other medication		contect that is attached. S Re-write Attachement A.	ee		

000459

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	1		COMPLETED	
		155567	B. WING		_	03/03/2011	
			_	REET ADDRESS, C	ITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	2		00 MEDICAL F			
UNIVERS	SITY PARK HEALTH	HAND REHABILITATION CENT		PRT WAYNE, IN			
(X4) ID		STATEMENT OF DEFICIENCIES	ID		OVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREF	CROSS-RE	ORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA	3	DEFICIENCY)	DATE	
	Preparation and	Medication					
	Administration r	evised dated 5/1/2010					
	supplied on 3/3/2011 by the Director of						
		d " 4.1 Facility staff					
	-	onfirm that the MAR					
		ninistration Record)					
	`	recent medication					
		recent incurcation					
	order"						
	11	0.14.0.2.2.2					
	Indiana code 848						
		s a member of the health					
		3.) Communicate,					
	collaborate, and	function with other					
	members of the l	health care team to					
	provide safe and	effective care"					
	_						
	3.1-35(g)(1)						

PRINTED: 04/01/2011 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-0391
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED	
		155567	B. WIN			03/03/2	011
		<u> </u>	P		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			IEDICAL PARK DRIVE		
UNIVER	SITY PARK HEALTI	HAND REHABILITATION CENTE	ĒR		WAYNE, IN46825		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	+		DATE
F0282	Based on observ	ration, interview and	F02	82	It is the policy of this facility th	at	04/01/2011
SS=D	record review, th	ne facility failed to ensure			the services provided or		
00-D	protective clothi	ng was applied as			arranged, be provided by		
	1 ^	lan of care for 3 of 10			qualified persons in accordance		
	_	ed with protective			with each resident's written plan of care: Resident #24, #26, ar		
		_			#23 has TARs and Careplans	iu	
	_	al sample of 18. (Resident			reviewed by DON. Protective		
	# 24, Resident #	26, and Resident #23)			garments applied to Resident		
					#23. TED Hose applied to		
	Findings include	2:			Resident #24 and #26. ADL F	Plan	
					of Care updated for Resident	#23.	
	1. Resident #24's	s record was reviewed			DON reviewed all residents'		
	2/28/11 at 1 p.m				TARs/Careplans for protective	:	
	_				garments and/or TED Hose required to ensure accuracy o	£	
	_	led, but were not limited			regulated to ensure accuracy of residents' careplans. DON or		
	to, depression, a	anemia, and osteoporosis.			designee to add necessary		
					changes in the Vocollect ADL		
	Physician's order	r sheets dated February			Plan of Care. Licensed nursir	ng	
	and March 2011	indicated Knee high TED			staff and CNA's to apply		
	(thromboemboli	tic reduction device) hose			protective garments and TED		
	were to be applied	ed in the morning and			hose per physician order and/		
		evening to reduce			nursing measure. Floor nurse		
		ood clots in her legs.			verify and document in TAR the protective garments and TED	ıat	
	possibility of bit	ood clots in her legs.			hose have been applied. Rand	dom	
	0.0000011	11.00			visual monitoring of residents		
		11:30 a.m., Resident #24			be performed by DON or		
	was observed up	in her wheelchair in her			designee. Interdisciplinary Te	am	
	room. No TED l	nose were on.			to update careplans according	j to	
					resident needs and physician		
	On 3/1/2011 at 1	1:30 a.m., Resident #24			orders. Interdisciplinary Team	ı to	
		her room no TED hose			ensure Vocollect plan of care		
	were on.				matches careplans upon completion of resident's IDT		
	WCIC OII.				rounds. Quality Assurance		
	0.0000000	5.05			Committee to monitor for 3 months. Addendum:Random		
		6:05 a.m., Resident #24					
	was up in her wh	heelchair no TED hose			visual monitoring of 50% of		
	were on.				residents with protective		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/02/2011			
		155567	B. WING		03/03/2011		
	PROVIDER OR SUPPLIER	HAND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DRIVE FORT WAYNE, IN46825				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	Resident #24 ind wore TED hose to she did not need In an interview 3 LPN #1 indicated have TED hose of the Areview of Nursperiod of 2/28/20 not indicate Resilowear TED hose. 2. Resident #26's 3/2/2011 at 2 p.n. diagnoses included in the diagnoses included in the properties of the	d Resident #24 should on. Sing Notes for the time on through 3/2/2011 did dent #24 had refused to record was reviewed n. Resident #26's ed but were not limited to tive heart failure, and		garments and/or TED Hose to performed by DON or designed on various shifts, including weekends. Interdisciplinary To update careplans according resident needs and physician orders. Interdisciplinary Team ensure Vocollect plan of care matches careplans upon completion of resident's IDT rounds. Quality Assurance to review results monthly x6 more or until pattern of consistent compliance achieved with a subsequent plan developed a implemented as indicated.	ream g to n to		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/03/2011		
NAME OF F	PROVIDER OR SUPPLIER	!!		STREET A	DDRESS, CITY, STATE, ZIP CODE	!	
		HAND REHABILITATION CENTE	ER	1	VAYNE, IN46825		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	was observed pro 200 hall. No TE	opelling herself on the D hose were on.					
		3/3/2011 at 10 a.m., LPN ident #26 should have her					
	Resident #23 on indicated the fol	clinical record for 2/28/11 at 1:04 p.m., lowing: diagnoses					
	included, but were not limited to, Alzheimer's dementia with agitation and hitting and failure to thrive.						
	dated 3/1/11, inc	n orders for Resident #23, licated geri sleeves at all g measure with a start					
	Skin Condition f	e of Condition Report - For Resident #23, dated and a skin tear was found cm.					
	Skin Condition f 9/30/10, indicate her right forearm Condition Report	e of Condition Report - for Resident #23, dated ed a skin tear was noted to n. The Change of et also indicated Resident geri sleeves to her es at all times.					
	A facility Chang	e of Condition Report -					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/03/2011		
	PROVIDER OR SUPPLIER SITY PARK HEALTH	I AND REHABILITATION CENTE	-	STREET A	DDRESS, CITY, STATE, ZIP CODE EDICAL PARK DRIVE VAYNE, IN46825	1	
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY OR Skin Condition for 10/14/10, indicate on her right foreast	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) or Resident #23, dated ed a skin tear was found arm. an for Resident #23, with		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE .	(X5) COMPLETION DATE
	an initiation date	of 5/20/10 and a review indicated geri sleeves					
	Resident #23, da skin was intact b Interdisciplinary indicated her skin a history of skin Interdisciplinary	Progress Note also n was at risk secondary to tears. The Progress Note further s to wear geri sleeves to					
	CNA #3) were in 10:06 a.m. Durin indicated the care was programmed wore. They also programmed hea	g Assistants (CNA #2, terviewed on 3/2/11 at ing the interview they e each resident required l into the headsets they indicated the dsets would prompt them re each resident required.					
	living) Plan of Coprovided by the A at 10:30 a.m., inc	ADL (activities of daily are for Resident #23, Administrator on 3/2/11 dicated all areas of care e areas of care were the					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/03/2011	
	PROVIDER OR SUPPLIER	HAND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DRIVE FORT WAYNE, IN46825				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	headsets each Cl	ogrammed into the NA wore. The printed re did not include the geri es.					
	During the intervent physician orders entered into the land nursing staff. Howevering the head identify the room system would preach resident requirements was in 9:40 a.m. During indicated the fact policy on follow	/2/11 at 3:05 p.m. view he indicated for resident care were neadset system by the e also indicated while lisets, CNA's were able to n of the resident and the compt them on what care quired. rector of Clinical nterviewed on 3/3/11 at g the interview she ility did not have any ing physician orders. She was a standard practice to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	155567		B. WING			03/03/2011	
NAME OF PROVIDER OR SUPPLIER UNIVERSITY PARK HEALTH AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DRIVE FORT WAYNE, IN46825				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		Ē	(X5) COMPLETION DATE	
F0514 SS=D	Based on interviet the facility failed documentation red 1 of 15 residents administration do sample of 18. (Referring Findings included Resident #24's red 2/28/11 at 1 p.m. diagnoses included to, depression, and A.) A physician's indicated to start given every day for the A Medication Addated February 2 had been started a signature indication been given on 2/2. The Medication Addated March 201 a medication that A review of the codid not indicate the had been discontinuation.	ew and record review, to ensure accurate egarding medications for reviewed for medication ocumentation in a total esident #24) cord was reviewed Resident #24's ed, but were not limited nemia, and osteoporosis. corder dated 2/25/11 Enablex 7.5 mg to be for overactive bladder. ministration Record 011 indicated Enablex 2/27. There was noting the medication had 28. Administration Record 1 did not list Enablex as a was to be given. current physician's orders he medication Enablex inued.	F05		It is the practice of this facility is maintain clinical records on earesident in accordance with accepted professional standar and practices that are complet accurately documented; readil accessible; and systematically organized. Resident #24 physician orders reviewed by DON. Transcription Error Repwritten by DON for Enablex and Ferrex. Enablex noted in Mark MAR. Attending physician and Resident #24 notified of transcription error. DON or designee to perform facility with review of all residents' MARs the ensure accuracy with physician orders. Licensed nursing staff re-educated on proper Medical Administration and Monthly Re-write of MARs protocol. Undersidents' MARS upon comple of monthly re-writes for 3 month Unit Managers to report finding to DON. DON or designee to perform random reviews of re-writes for 6 months of residents' MARs. Quality Assurance to review result for 6 months or until pattern of consistent compliance achieved was undersidented as indicated.	to ch ds e; yy ort id ch de o n tion it tion ths. gs	DATE 04/01/2011
	in an interview o	n 3/2/2011 at 1:30 p.m.					

AND PLAN OF CORRECTION IDENTI		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		155567	- 1	A. BUILDING B. WING			03/03/2011	
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP CODE	1		
UNIVERSITY PARK HEALTH AND REHABILITATION CENTE			1400 MEDICAL PARK DRIVE TER FORT WAYNE, IN46825					
(X4) ID				ID			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	PROVIDER'S PLAN OF CORRECTION		COMPLETION	
TAG				TAG	DEFICIENCY)	DATE		
	LPN #1 indicated Enablex should have been given. Additionally, medications ordered the last week of the month should be noted on the next month's Medication Administration Record by the nurse							
	taking the order.							
	aking the order.							
	In an interview on 3/2/2011 at 2:05 p.m.							
		d Enablex had been given						
	without documer	ntation of administration						
	on the Medicatio	n Administration Record.						
		ablex medication card						
	* * *	Director of Nursing on						
		ed 16 tablets had been						
	* *	acility on 2/26/2011. 4 taken from the card.						
	tablets had been	taken nom the card.						
	B.) A physician's order dated 1/17/2011							
	indicated Ferrex	150 mg was to be given						
	twice daily for 30	0 days to Resident #24.						
		fedication Administration						
		bruary 2011 indicated						
		given twice daily 2/17						
	date of 2/16/2011	spite the automatic stop						
	uate 01 2/10/2011	1,						
	In an interview o	on 3/3/2011 at 9:10 a.m.,						
		fursing indicated Ferrex						
	should not have l							
	2/16/2011.							

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155567		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/03/2011	
NAME OF PROVIDER OR SUPPLIER UNIVERSITY PARK HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DRIVE				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE	
	the Director of n had not been gived medication was a Additionally, the medications 2/17 should not have had been given. On 3/3/2011 at 1 delivery docume Director of Nurs #24 had been sup 1-17-2011 numb availability of the 2/16/2011. A policy entitled Preparation and Administration response to the Director of 10:05 a.m. indicated medication administration admini	conurse administering through 2/28/2011 documented the Ferrex 0:05 a.m., a proof of nt was provided by the ing indicated Resident oplied Ferrex on ering 60 limiting e medication after General Dose Medication evised 5/1/2010 provided of Nursing on 3-3-2011 at atted "6. After nistrationdocument ation administrationon					